SERFF Tracking Number:	*AOIC-127752553*	*State:*	*Arkansas*
Filing Company:	*Auto-Owners Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*AR-LTC-10/11*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*Long-Term Care*		
Project Name/Number:	*Long-Term Care/AR-LTC-10/11*		

Filing at a Glance

Company: Auto-Owners Life Insurance Company

Product Name: Long-Term Care	SERFF Tr Num: AOIC-127752553	State: Arkansas
TOI: LTC03I Individual Long Term Care	SERFF Status: Closed-Approved	State Tr Num:
Sub-TOI: LTC03I.001 Qualified	Co Tr Num: AR-LTC-10/11	State Status: Approved-Closed
Filing Type: Form/Advertisement		Reviewer(s): Donna Lambert
	Authors: Christie Janell, Amanda Rivera, Tonia Skaar	Disposition Date: 01/30/2012
	Date Submitted: 01/26/2012	Disposition Status: Approved
Implementation Date Requested: On Approval		Implementation Date: 03/01/2012

State Filing Description:

General Information

Project Name: Long-Term Care	Status of Filing in Domicile: Authorized
Project Number: AR-LTC-10/11	Date Approved in Domicile: 08/03/2011
Requested Filing Mode:	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type:
Overall Rate Impact:	Filing Status Changed: 01/30/2012
	State Status Changed: 01/30/2012
Deemer Date:	Created By: Amanda Rivera
Submitted By: Amanda Rivera	Corresponding Filing Tracking Number:

Filing Description:

Auto-Owners Life Insurance Company of Lansing, Michigan submits form 50134(3-11) et al and riders.
The policy is a Tax-Qualified Long-Term Care Insurance Policy. This policy is a non-participating policy and is guaranteed renewable for life. The issue ages for this policy are changing from 18-100 to 18-80. The form changes were made to satisfy state regulations. There will be no change to our Long-Term Care Insurance rates.

The following forms have been updated to satisfy state regulation:

Form #50134 (3-11) et al. - Long-Term Care Policy
Form # 50479 (1-11) - 3% Compound Benefit Increase Rider
Form # 50129 (1-11) - 5% Compound Benefit Increase Rider
Form # 50130 (1-11) - Non-Forfeiture Benefit Rider

SERFF Tracking Number:	*AOIC-127752553*	*State:*	*Arkansas*
Filing Company:	*Auto-Owners Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*AR-LTC-10/11*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*Long-Term Care*		
Project Name/Number:	*Long-Term Care/AR-LTC-10/11*		

Form #50126 (11-10) - Application
Form #61961 (7-11) - Statement of Insurability
Form # 50410 (1-11) - Personal Worksheet
Form #61674 (10-09) - Potential Rate Increase
Form #50392 (1-11) - Outline of Coverage
Form # 61785 (12-10) Things You Should Know Before You Buy Long-Term Care Insurance
Form # 61673 (12-10) Notice To Applicant Regarding Replacement

The attached forms are submitted in final printed format and are subject only to minor modifications, such as company address, logo and phone number, typographical errors, paper stock, ink and adaption to computer printing.

We use the direct sales approach by agents to market our products. Auto-Owners marketing method for Long-Term Care Insurance is individual sales.

All funds are held in a general account.

We have reviewed all applicable product and rider checklists and feel our product complies with all regulations. May we please have your approval?

Company and Contact

Filing Contact Information

Amanda Rivera,
544 Cherbourg Dr.
Ste 200
Lansing, MI 48917-5009

rivera.amanda@aoins.com
517-391-1054 [Phone]

Filing Company Information

Auto-Owners Life Insurance Company
P.O. Box 30325
Lansing, MI 48917

(800) 346-0346 ext. [Phone]

CoCode: 61190
Group Code: 280
Group Name: Auto-Owners Ins Group
FEIN Number: 38-1814333

State of Domicile: Michigan
Company Type: LAH
State ID Number:

Filing Fees

SERFF Tracking Number:	*AOIC-127752553*	*State:*	*Arkansas*
Filing Company:	*Auto-Owners Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*AR-LTC-10/11*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*Long-Term Care*		
Project Name/Number:	*Long-Term Care/AR-LTC-10/11*		

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	Yes
Fee Explanation:	$50.00 Filing Fee for 50134 (3-11) et al
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Auto-Owners Life Insurance Company	$50.00	01/26/2012	55847590
Auto-Owners Life Insurance Company	$600.00	01/27/2012	55874483

SERFF Tracking Number:	*AOIC-127752553*	*State:*	*Arkansas*
Filing Company:	*Auto-Owners Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*AR-LTC-10/11*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*Long-Term Care*		
Project Name/Number:	*Long-Term Care/AR-LTC-10/11*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	01/30/2012	01/30/2012

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Donna Lambert	01/27/2012	01/27/2012	Tonia Skaar	01/27/2012	01/27/2012

SERFF Tracking Number:	*AOIC-127752553*	*State:*	*Arkansas*
Filing Company:	*Auto-Owners Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*AR-LTC-10/11*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*Long-Term Care*		
Project Name/Number:	*Long-Term Care/AR-LTC-10/11*		

Disposition

Disposition Date: 01/30/2012
Implementation Date: 03/01/2012
Status: Approved
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AOIC-127752553*	*State:*	*Arkansas*
Filing Company:	*Auto-Owners Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*AR-LTC-10/11*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*Long-Term Care*		
Project Name/Number:	*Long-Term Care/AR-LTC-10/11*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Health - Actuarial Justification	Approved	Yes
Supporting Document	Outline of Coverage	Approved	Yes
Supporting Document	Statement of Variability	Approved	Yes
Form	Front Jacket	Approved	Yes
Form	Data Page	Approved	Yes
Form	Policy Pages	Approved	Yes
Form	3% Benefit Increase Rider	Approved	Yes
Form	5% Benefit Increase Rider	Approved	Yes
Form	Non-Forfeiture Benefit Rider	Approved	Yes
Form	LTC Application	Approved	Yes
Form	Statement of Insurability	Approved	Yes
Form	Policy Back Jacket	Approved	Yes
Form	Potential Rate Increase Disclosure	Approved	Yes
Form	Personal Worksheet	Approved	Yes
Form	Replacement Notice	Approved	Yes
Form	Things You Should Know Before You Buy Long-Term Care Insurance	Approved	Yes

SERFF Tracking Number:	*AOIC-127752553*	*State:*	*Arkansas*
Filing Company:	*Auto-Owners Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*AR-LTC-10/11*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*Long-Term Care*		
Project Name/Number:	*Long-Term Care/AR-LTC-10/11*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	01/27/2012
Submitted Date	01/27/2012
Respond By Date	02/27/2012

Dear Amanda Rivera,

The filing fee submitted is incorrect. We will accept the domicile state fees only if the domicile state fees are greater than the fees outlined for the State of Arkansas. The fee for this submission is $50 per form for a total of $650. Please submit an additional $600.

We will begin our review of this submission upon receipt of the additional filing fee.

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.
Sincerely,
Donna Lambert

SERFF Tracking Number:	*AOIC-127752553*	*State:*	*Arkansas*
Filing Company:	*Auto-Owners Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*AR-LTC-10/11*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*Long-Term Care*		
Project Name/Number:	*Long-Term Care/AR-LTC-10/11*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	01/27/2012
Submitted Date	01/27/2012

Dear Donna Lambert,

Comments:
Thank you for your prompt attention to this filing.

Response 1

Comments: Auto-Owners Life Insurance Company has remitted the required $600.00 payment via EFT.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

We hope this allows you to continue your review of this filing.

Thank you,

Tonia Skaar
Amanda Rivera

Sincerely,
Amanda Rivera, Christie Janell, Tonia Skaar

SERFF Tracking Number:	*AOIC-127752553*	*State:*	*Arkansas*
Filing Company:	*Auto-Owners Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*AR-LTC-10/11*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*Long-Term Care*		
Project Name/Number:	*Long-Term Care/AR-LTC-10/11*		

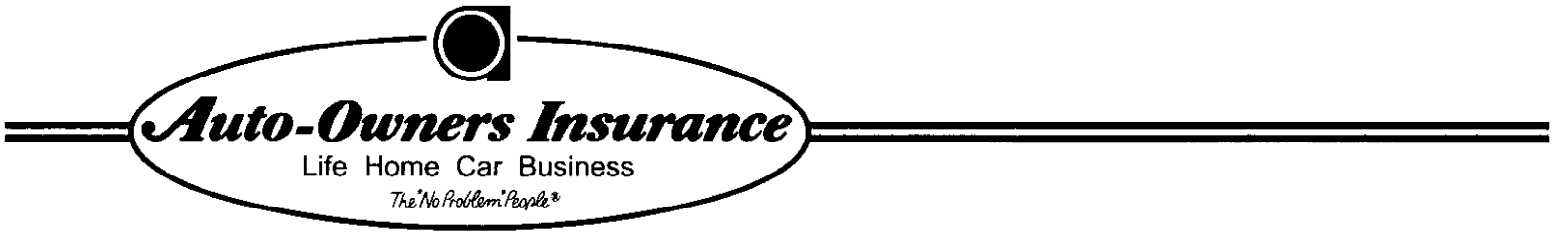
Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 01/30/2012	50134 (3-11)	Policy Jacket	Front Jacket	Revised	Replaced Form #: 50134 (10-01) Previous Filing #:	66.410	50134 (3-11).pdf
Approved 01/30/2012	50135 (7-11)	Data/Declaration Pages	Data Page	Revised	Replaced Form #: 50135 (1-02) Previous Filing #:		50135 (7-11) - 2.pdf
Approved 01/30/2012	61976 (8-11)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Policy Pages	Revised	Replaced Form #: 60136 (10-05) Previous Filing #:	50.210	61976 (8-11).pdf
Approved 01/30/2012	50479 (1-11)	Certificate Amendment, Insert Page, Endorsement or Rider	3% Benefit Increase Rider	Revised	Replaced Form #: 50479 (10-05) Previous Filing #:	58.010	50479 (1-11).pdf
Approved 01/30/2012	50129 (1-11)	Certificate Amendment, Insert Page, Endorsement or Rider	5% Benefit Increase Rider	Revised	Replaced Form #: 50129 (10-01) Previous Filing #:	60.520	50129 (1-11).pdf
Approved 01/30/2012	50130 (1-11)	Certificate Amendment, Insert Page,	Non-Forfeiture Benefit Rider	Revised	Replaced Form #: 50130 (10-05) Previous Filing #:	68.320	50130 (1-11).pdf

SERFF Tracking Number:	*AOIC-127752553*	*State:*	*Arkansas*	
Filing Company:	*Auto-Owners Life Insurance Company*	*State Tracking Number:*		
Company Tracking Number:	*AR-LTC-10/11*			
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*	
Product Name:	*Long-Term Care*			
Project Name/Number:	*Long-Term Care/AR-LTC-10/11*			

		Endorsement or Rider				
Approved 01/30/2012	50126 (11-10)	Application/ Enrollment Form	LTC Application	Revised	Replaced Form #: 50126 (9-05) Previous Filing #:	50126 (11-10).pdf
Approved 01/30/2012	61961 (7-11)	Application/ Enrollment Form	Statement of Insurability	Initial		61961(7-11).pdf
Approved 01/30/2012	50133 (12-10)	Policy Jacket	Policy Back Jacket	Revised	Replaced Form #: 50133 (10-01) Previous Filing #:	50133 (12-10).pdf
Approved 01/30/2012	61674 (10-09)	Other	Potential Rate Increase Disclosure	Initial		61674 (10-09).pdf
Approved 01/30/2012	50410 (1-11)	Other	Personal Worksheet	Revised	Replaced Form #: 50127 (10-01) Previous Filing #:	50410 (01-11).pdf
Approved 01/30/2012	61673 (12-10)	Other	Replacement Notice	Revised	Replaced Form #: 61017 (9-02) Previous Filing #:	61673 (12-10).pdf
Approved 01/30/2012	61785 (12-10)	Other	Things You Should Know Before You Buy Long-Term Care Insurance	Revised	Replaced Form #: 60171 (6-05) Previous Filing #:	61785 (12-10).pdf



TAX-QUALIFIED COMPREHENSIVE LONG-TERM CARE INSURANCE POLICY

THIS POLICY IS INTENDED TO BE A QUALIFIED LONG-TERM CARE INSURANCE CONTRACT UNDER THE FEDERAL TAX CODE AS DEFINED UNDER SECTION 7702B(b) OF THE INTERNAL REVENUE CODE.

IMPORTANT CAUTION ABOUT YOUR APPLICATION

This Policy was issued based on Your answers to the questions on Your application and payment of the first premium. A copy of Your application is attached. If Your answers are incorrect or untrue, We may have the right to deny Benefits or rescind Your Policy. The best time to clear up any questions is now, before a claim arises! If for any reason, any of Your answers are incorrect, please contact us at: Auto-Owners Life Insurance Company, P. O. Box 30325, Lansing, MI 48909. We can be contacted at 1-517-323-1200.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY

If You are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from Auto-Owners Life Insurance Company.

GUARANTEED RENEWABLE FOR LIFE

This Policy will remain in force during Your lifetime as long as premiums are paid on time. The contract expires when the Maximum Lifetime Benefit has been reached. The premiums may change, but only if We change the premium rates for all persons in the same rate class. In the event of a rate class increase, such increase will be based on Your original issue age. This rate change will occur on the next annual Policy Date following the date of change in the premium rate tables. The Company cannot cancel, refuse to renew or change any provisions other than rates.

THIRTY (30) DAY FREE LOOK

If this Policy is not satisfactory for any reason, it can be returned to Us or Your agent within thirty (30) days of the date it was delivered. We will refund any premium paid within thirty (30) days. The Policy will be considered to have never been issued.

NOTICE TO BUYER

This Policy may not cover all of the costs associated with Long-Term Care, which may be incurred by You during the period of coverage. You are advised to periodically review this Policy in relation to the changes in the cost of Long-Term Care and carefully review all Policy provisions.

READ YOUR POLICY CAREFULLY

It is a legal contract between You and Us.

This Policy has been executed at Lansing, Michigan on the Policy Date unless otherwise stated on the Policy Data Page.

[Jane Secretary]
Secretary

[Joe President]
President

Auto-Owners Life Insurance Company
P.O. Box 30325
Lansing, Michigan 48909

TABLE OF CONTENTS

A copy of Your application and any additional Benefits purchased are attached and made part of this Policy.

Auto-Owners Life Insurance Company
(Herein Called the Company)
Lansing, Michigan 48909-8160

POLICY DATA

INSURED:	[JOHN DOE]	POLICY NUMBER:	[025-999999-0]
OWNER:	[JOHN DOE]	POLICY DATE:	[JUNE 1, 2011]
PLAN:	LONG-TERM CARE INSURANCE		12:01 A.M. STANDARD TIME AT THE
GENDER:	[MALE]		RESIDENCE OF THE INSURED
ISSUE AGE:	[60]	PREMIUM CLASS:	[STANDARD]

SCHEDULE OF BENEFITS AND PREMIUMS

MAXIMUM LIFETIME BENEFIT AT POLICY INCEPTION	[$219,000.00]
BENEFIT PERIOD	[6] YEARS
FACILITY DAILY BENEFIT AMOUNT	[$100.00]
HOME AND/OR COMMUNITY CARE DAILY BENEFIT AMOUNT (IF APPLICABLE)	[$100.00]
ELIMINATION PERIOD	[30] DAYS
BED RESERVATION	[21] DAYS PER CALANDER YEAR
BASE COVERAGE PREMIUM	[$1,201.00]
[ADDITIONAL BENEFITS]	
[NON-FORFEITURE BENEFIT RIDER	[ANNUAL PRMEMIUM FOR RIDER]]
[3% COMPOUND BENEFIT INCREASE RIDER	[ANNUAL PREMIUM FOR RIDER]]
[5% COMPOUND BENEFIT INCREASE RIDER	[ANNUAL PREMIUM FOR RIDER]]
TOTAL ANNUAL PREMIUM:	[1,201.00]

PREMIUM MODE OPTIONS

PREMIUM MODE	TOTAL PREMIUM
MONTHLY:	[103.29]
QUARTERLY:	[318.27]
SEMI-ANNUAL:	[654.52]
ANNUAL:	[1201.00]

DEFINITIONS

The following words have special meanings. They are important in describing Your rights and Our rights under this Policy. Refer back to these meanings as You read Your Policy.

Activities of Daily Living means the following functions allowing for personal independence in every day living, which are used as one measurement standard to determine Your eligibility for Benefits:

Bathing: washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.

Continence: the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

Dressing: putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

Eating: feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

Toileting: getting to and from the toilet, getting on and off the toilet and performing associated personal hygiene.

Transferring: moving into or out of a bed, chair or wheelchair.

Adult Day Care means a program of social and health-related services for six (6) or more individuals, which is provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home.

Adult Day Care Center means an institution that is licensed to provide Adult Day Care in accordance with state laws in which preventive, remedial and restorative services are provided in a protective environment for part of the twenty-four (24) hour day. If licensing is not required, Adult Day Care Center means a place that:

- provides Adult Day Care; and
- maintains a daily written record of each client who receives services; and
- has a staff including, at least, a director, one (1) full-time licensed nurse and enough full-time staff to maintain no more than an eight (8) to one (1) client ratio; and
- has established procedures for obtaining appropriate aid in the event of a medical emergency.

Assisted Living Facility means an institution that is licensed by the appropriate federal or state agency to engage primarily in providing care and unscheduled services to at least ten (10) resident inpatients in one (1) location and meets all of the following criteria:

- provides twenty-four (24) hour-a-day care and services sufficient to support the needs of a Chronically Ill Individual; and
- has a trained and ready to respond employee on duty at all times to provide that care and services; and
- provides three (3) meals a day and accommodates special dietary needs; and
- has arrangements with a physician or nurse to furnish medical care in the case of an emergency; and
- has the appropriate methods and procedures to provide necessary assistance to residents in the management of prescribed medications.

If an institution (such as a congregate care facility or life care community) has multiple licenses for multiple purposes, only the portion, ward, wing or unit (including a separate room or apartment) that specifically provides the above described care and meets all of the above requirements will qualify as an Assisted Living Facility.

Benefits mean a monetary sum payable to You for Qualified Long-Term Care.

Calendar Year means the period beginning on January 1st of any year and ending at 12:01 A.M. on January 1st of the following year at Your primary residence.

Chronically Ill Individual means an individual who, within the preceding twelve (12) months, has been certified by a Licensed Health Care Practitioner as:

being unable to perform, without Substantial Assistance from another individual, two (2) or more of the Activities of Daily Living for an expected

period of at least ninety (90) days due to a loss of functional capacity; or

- requiring Substantial Supervision to protect himself or herself from threats to health and safety due to Severe Cognitive Impairment.

Written certificate must be renewed or updated at least every twelve (12) months.

Elimination Period means the number of days at the beginning of a continuous period for which You have been certified as a Chronically Ill Individual and for which Benefits are not payable. The Elimination Period must be satisfied only once during the lifetime of Your Policy. The Elimination Period for this Policy is shown on the Policy Data Page.

Facility Daily Benefit Amount means the dollar amount shown on the Policy Data Page We will pay You for each day You receive Qualified Long-Term Care in a facility covered under this Policy. The Facility Daily Benefit Amount is subject to increase when a Compound Benefit Increase Rider is purchased.

Home and/or Community Daily Benefit Amount means the dollar amount shown on the Policy Data Page We will pay for each day You receive Qualified Long-Term Care in a home or community-based setting covered under this Policy. The Home and/or Community Daily Benefit Amount is subject to increase when a Compound Benefit Increase Rider is purchased.

Home Health Aide and Personal Care Attendant means any Qualified Long-Term Care, which involves assistance that a Home Health Aide or Personal Care Attendant employed by a licensed Home Health Care agency provides to You. Such services include simple health care tasks, personal hygiene, help performing Activities of Daily Living, managing medications and other related supportive services.

Home Health Care means medical and nonmedical services provided to a Chronically Ill Individual in his/her residence. These services may include assistance with Activities of Daily Living.

Hospice Care means a planned program for meeting Your care needs if You are terminally ill.

Hospice Facility means an institution meeting the regulatory requirements for a Hospice Facility in the state where the services are rendered. If such a state has no regulatory requirements, the agency must:

- be primarily engaged in providing pain relief, symptom management and support service to dying persons and their Immediate Family; and
- provide Nursing Care under the supervision of a Registered Nurse.

Hospital Long-Term Care Unit means an acute general hospital with wards, wing units or beds assigned for Long-Term Care. Such a hospital must be certified or accredited by the state, Medicare or the Joint Commission on Accreditation of Health Care Organizations.

Immediate Family means anyone related to You in the following manner: spouse, brother or sister (includes stepbrother or stepsister), children (includes stepchildren), spouse of any of the above, parents (includes stepparents) or grandchildren (includes stepgrandchildren).

Licensed Health Care Practitioner means any physician (as defined in section U.S.C. 1861(r)(1) of the Social Security Act, as amended), any Registered Nurse, any Licensed Social Worker or other individual who meets such requirements as may be prescribed by the Secretary of the Treasury.

Maintenance or Personal Care means care primarily for providing needed assistance to a Chronically Ill Individual including the protection from threats to health and safety due to Severe Cognitive Impairment.

Maximum Lifetime Benefit means the total amount of coverage available under this Policy to pay for Qualified Long-Term Care. It applies to the combined total of all Benefit payments. The amount that applies on the Policy Date is shown on the Policy Data Page. The Maximum Lifetime Benefit is subject to increase when a Compound Benefit Increase Rider is purchased.

Medicare means The Health Insurance for Aged Act, Title XVIII of the Social Security Act Amendments of 1965, as constituted and later amended.

Nursing Care means services providing skilled or intermediate care provided by one (1) or more of the following health care professionals: Registered Nurse, Licensed Vocational Nurse, Licensed Practical Nurse, Physical Therapist, Occupational Therapist, Speech Therapist, Respiratory Therapist, Licensed/Certified Social Worker.

Owner means the insured unless someone else is named as Owner in the application. The Owner's rights end at the insured's death.

Plan of Care means a written guide for Qualified Long-Term Care designed especially for You that:

-
- fairly, accurately and appropriately addresses Your needs for Long-Term Care; and

- is acceptable to Us, You and Your physician; and
- utilizes Qualified Long-Term Care.

The Plan of Care will specify the type, frequency and Providers of all the services You require and must be prescribed by a Licensed Health Care Practitioner.

The Plan of Care is to be completed once You have met the Eligibility for the Payment of Benefits requirements and expect to receive Qualified Long-Term Care under this Policy. Your Plan of Care may need to be updated periodically as appropriate based on Your condition or upon Our request.

Policy means this legal contract between You and Us, including Your application and any riders or endorsements.

Provider(s) means any licensed or certified health professional, Adult Day Care Center, Assisted Living Facility, Hospice Facility, Skilled Nursing Facility, Hospital Long-Term Care Unit Facility or other entity, facility or person that is working within the scope of his/her license and are able to provide Qualified Long-Term Care as defined in this Policy.

Qualified Long-Term Care means services for necessary diagnostic, preventive, therapeutic, curing, treating, mitigating and rehabilitative services and Maintenance or Personal Care services, which are required by a Chronically Ill Individual and are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner.

Severe Cognitive Impairment means a deterioration or loss in Your intellectual capacity which places You in jeopardy of harming Yourself or others unless You receive Substantial Supervision. Your Severe Cognitive Impairment must be established by clinical evidence and standardized tests which reliably measure loss of:

- short or long-term memory; and
- orientation as to person (such as who You and others are), place (such as Your location) and time (such as day, date and year); and
- deductive or abstract reasoning; and
- judgement as it relates to safety and awareness.

This Policy will cover disorders with demonstrable organic cause such as Alzheimer's disease or similar forms of senility or irreversible dementia that results in Severe Cognitive Impairment.

Skilled Nursing Facility means an institution, which is licensed by the state where it is located and provides Skilled, Intermediate, Custodial, and Nursing Care on an inpatient basis under the supervision of a physician and/or licensed nurse and meets all of the following criteria:

- provides twenty-four (24) hour-a-day Nursing Care services under the supervision of a Registered Nurse, Licensed Vocational Nurse or Licensed Practical Nurse; and
- keeps a daily medical record of each patient; and
- is either a freestanding facility or a distinct part of a facility such as a ward, wing unit or swing-bed of a hospital or other institution.

It does not mean: a hospital or a place that primarily treats the mentally ill, drug addicts or alcoholics.

Substantial Assistance means the support of another person who must provide physical hands-on assistance or who must be within arm's reach of You to prevent, by physical intervention if necessary, injury while You perform an Activity of Daily Living.

Substantial Supervision means continual supervision, which may include cueing by verbal prompting, gestures or other demonstrations by another person that is necessary to protect You from harming Yourself or others when You have a Severe Cognitive Impairment.

You, Your, Yourself means the person insured under this Policy as shown on the Policy Data Page.

We, Us, Our, The Company means Auto-Owners Life Insurance Company.

BENEFITS

CONTINGENT NON-FORFEITURE BENEFIT
If the Non-Forfeiture Benefit Option Rider is not purchased, the following options are available every time The Company increases premium rates substantially.

The Owner may elect:

- to reduce the Maximum Lifetime Benefit, without the requirement of additional underwriting, in order to reduce the required premium payments; or

- to continue coverage under the Contingent Non-Forfeiture Benefit provision described below.

A substantial premium rate increase will be deemed to have occurred if Your premium rate increases to a specified percentage over Your premium amount. This specific percentage is called the percent of increase over initial premium. The percent of increase that applies to You depends on Your issue age. Issue age means Your age on the Policy effective date.

The purchase of additional coverage, and the increase in premium that results, will not be considered a substantial premium rate increase; however, the premium for the additional coverage will be considered part of the initial premium amount. A reduction in Benefits will not be considered a premium rate change; however, the initial premium amount will be based on the reduced Benefits.

If Your coverage lapses due to nonpayment of the required premiums, within 120 days of the due date of a substantial premium rate increase, this Policy may be continued under this Contingent Non-Forfeiture Benefit option without further premium payments, subject to all the terms and conditions of this Policy.

This means that this Policy will continue automatically with the same level of Benefits except for a reduction in the Maximum Lifetime Benefit. However, no inflation protection increases (if included in the Policy) will be made after the end of the period for which premiums were last paid to The Company for this Policy.

The Maximum Lifetime Benefit will be equal to 100% of all premiums paid, including the premiums paid prior to any changes in Benefits. In no event, however, will the Maximum Lifetime Benefit be less than thirty (30) times one (1) Facility Maximum Daily Benefit payment.

Triggers Indicating a Substantial Premium Increase

Issue Age	Increase Over Initial Premium
29 & Under	200%
30 - 34	190%
35 - 39	170%
40 - 44	150%
45 - 49	130%
50 - 54	110%
55 - 59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 & over	10%

If Your Policy has a Non-Forfeiture Benefit Rider, that Rider will apply whenever the Policy lapses after having been in force for at least three (3) years (even if there has been no change in premium rates).

ELIGIBILITY FOR THE PAYMENT OF BENEFITS
To be eligible for Benefits provided by this Policy, You must be certified as a Chronically Ill Individual pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner. Certification must be made at least annually thereafter.

BENEFIT PAYMENT
A daily Benefit for Qualified Long-Term Care will be paid by Us directly to You once You have been certified as being eligible for Benefits. The daily Benefit is the Facility Daily Benefit or Home and/or Community Daily Benefit, depending on the site where care is provided. The cumulative sum of all Benefits paid cannot exceed the Maximum Lifetime Benefit as shown on the Policy Data Page.

YOUR BENEFITS
Under this Policy, Benefits are only paid when You are receiving Qualified Long-Term Care. All Benefits, except otherwise noted, are subject to the Elimination Period, applicable Daily Benefit Amount and Maximum Lifetime Benefit.

FACILITY BENEFITS
We will pay You the Facility Daily Benefit Amount, subject to the Elimination Period, for each day You receive Qualified Long-Term Care, which is provided in a Skilled Nursing Facility, Hospital Long-Term Care Unit, Hospice Facility, Assisted Living Facility or other approved facility.

HOME AND/OR COMMUNITY CARE BENEFITS
We will pay You the Home and/or Community Care Daily Benefit Amount, subject to the Elimination Period, for each day You receive Qualified Long-Term Care, which is provided in Your home or other community setting including Home Health Care, Home Health Aide and Personal Care Attendant Services, Adult Day Care and Hospice Care.

When You are receiving Qualified Home and/or Community Care, during the Elimination Period, per Your Policy Data Page, We will only require You to receive three (3) days of Qualified Long-Term Care, during a Sunday through Saturday week, to equal seven (7) days toward the Elimination Period.

BED RESERVATION BENEFIT
If You are receiving Qualified Long-Term Care in a Skilled Nursing Facility, Assisted Living Facility or other facility covered under this Policy and must be hospitalized temporarily, We will pay You the Facility Daily Benefit Amount for each day up to the number of days listed on the Policy Data Page per Calendar Year.

LOSSES NOT COVERED

LIMITATIONS OR CONDITIONS ON ELIGIBILITY FOR BENEFITS
This Policy will not pay a daily Benefit when:

- care is provided by Immediate Family members or for which the insured is not obligated to pay;
- care is provided outside the United States of America or its possessions;
- care is given for which no charge is normally made in the absence of insurance;
- care results directly or indirectly from an intentionally self-inflicted injury;
- care is provided free of charge by or in a Veteran's Administration or federal government facility;
- care results from mental illness or nervous disorders without demonstrable organic disease. (This Policy will cover disorders with demonstrable organic cause such as Alzheimer's disease or similar forms of senility or irreversible dementia that results in Severe Cognitive Impairment);
- care results from alcoholism or drug addiction, (but We will cover addiction to drugs administered in accordance with the advice and written instructions of a physician);
- illness, treatment or medical condition results from war or act of war, declared or undeclared;
- illness, treatment or medical condition is caused by the commission of a crime;
- care is given while incarcerated;
- care is provided during the Elimination Period;
- care is not included in the Plan of Care; or
- care given does not qualify as Long-Term Care.

This Policy does not contain a preexisting conditions limitation.

PREMIUM PROVISIONS

PAYMENT OF PREMIUMS
The premium payment methods are shown on the Policy Data Page. Premiums may be paid annually, semi-annually, quarterly or monthly. All premiums are payable at Our Home Office in Lansing, Michigan.

A change from one premium payment method to another may be made upon the Owner's written request while You are not a Chronically Ill Individual. If a premium is not paid on or before the due date, the premium is in default, and this Policy shall cease to be in force, except as is stated in the "Grace Period" provision.

If there is any change to the premium rate, We will notify the Owner thirty (30) days in advance. No change will be made in the premium amount unless We change the premium rates for all persons in the same rate class.

GRACE PERIOD
Except for the first premium, a premium not paid when due may be paid during the following thirty-one (31) days.

After thirty (30) days, a notice will be sent explaining that a payment has been missed and that the Policy risks lapsing. You will have an additional thirty-five (35) days from the date We mail such notice for payment of any unpaid premiums. Payment will allow Your Policy to continue in force without interruption. Failure to pay all unpaid premiums by the end of this thirty-five (35) day period will result in the termination of Your Policy.

UNINTENTIONAL LAPSE
In addition to Yourself and/or the Owner, a third party may be designated to be notified of lapse or termination. Notice will not be given until thirty (30) days after a premium is due and unpaid and shall be deemed to have been given as of five (5) days after the date of the mailing. The Owner may change the designee at any time by sending Us written notification.

WAIVER OF PREMIUM
After You have satisfied the Elimination Period, as shown on the Policy Data Page, We will not require continued premium payments in order to keep this Policy in force as long as: (a) You continue to receive Qualified Long-Term Care covered under this Policy; and (b) You have not exhausted Your Maximum Lifetime Benefit.

Once You are no longer eligible for Benefits, premium payments begin again if Your Policy is to remain in force subject to (b).

REINSTATEMENT
If a premium is not paid by the end of the Grace Period, this Policy will lapse. Later acceptance of a premium by Us, without requiring an application for reinstatement, will reinstate the Policy. If We require an application for reinstatement, a conditional receipt for that premium will be given. If Your application is approved, the Policy will be reinstated as of the date We approve the application. If We fail to give You written notice of approval or rejection within forty-five (45) days from the date of the conditional receipt, the Policy will be deemed reinstated at the end of that time.

The reinstated Policy will cover only loss resulting from injury, which occurs after the date of reinstatement and loss due to such sickness that begins more than ten (10) days after reinstatement.

In all other respects, each party will have the same rights as they had when the Policy lapsed. This is subject to any restrictions made a part of this Policy upon reinstatement.

REINSTATEMENT DUE TO SEVERE COGNITIVE IMPAIRMENT OR FUNCTIONAL IMPAIRMENT
If You fail to pay Your premium by the end of the Grace Period because You are a Chronically Ill Individual, You may request reinstatement up to six (6) months after termination of Your Policy. Your physician must submit proof that You were a Chronically Ill Individual and that caused You to fail to pay Your premium. We will require evidence of clinical diagnosis or tests demonstrating that You were a Chronically Ill Individual at the time of Policy termination before deciding reinstatement.

If Your Policy is reinstated, the premiums must be paid retroactively to the date Your Policy terminated. No Benefits will be paid for care or services received prior to the date We receive evidence from Your physician of Your loss.

UNEARNED PREMIUM
If Your Policy terminates due to cancellation or death, We will refund, on a pro-rata basis, the portion of any premiums paid which were to apply to periods following the termination. We will pay the refund directly to You, Your estate or the Owner.

CLAIM PROVISIONS

NOTICE OF CLAIM
Written Notice of Claim must be given to Us within thirty (30) days after the date of a loss, which renders You a Chronically Ill Individual and in need of Qualified Long-Term Care covered under this Policy or as soon after that as is reasonably possible. Notice of Claim given to Our Home Office at Lansing, Michigan or to Your agent, which is sufficient to identify You, will be deemed sufficient Notice of Claim.

CLAIM FORMS
When We receive a Notice of Claim, We will furnish Claim Forms for filing Proof of Loss. If We do not furnish these forms within fifteen (15) days of Our receipt of Notice of Claim, You will have fulfilled the requirements of this Policy for filing Proof of Loss upon sending Us written proof relating to the event, the character and extent of the loss for which the claim is made within the time granted under the "Proof of Loss" provision.

PROOF OF LOSS
In case of a claim for which this Policy provides periodic payments contingent upon continuing loss, acceptable written Proof of Loss must be furnished to Us at Our Home Office within ninety (90) days after the end of the period in which We are liable. Acceptable written Proof of Loss for any other claim for loss must be furnished to Us within ninety (90) days after the date of such loss.

Failure to furnish acceptable written Proof of Loss within that time will not reduce the claim if it was not reasonably possible to give proof within that time. However, Proof of Loss may not be furnished later than one (1) year from the time proof is normally required, except in the case of legal incapacity.

PHYSICAL EXAMINATION
We have the right to have You examined at Our expense during the course of a claim. We may do so as often as We find necessary.

TIME OF PAYMENT OF CLAIMS
We will pay all claims under this Policy for any covered loss except losses for which periodic payment is provided, within thirty (30) days upon receipt of acceptable written Proof of Loss. Subject to acceptable written Proof of Loss, all Benefits for any covered loss for which this Policy provides periodic payment will be paid at the end of each month during the continuance of the period for which We are liable. Any outstanding balance remaining upon the end of Our liability will be paid immediately upon receipt of acceptable written Proof of Loss.

CLAIM OVERPAYMENT
If for any reason, Benefits have been paid for which You were not entitled to Benefits, repayment of the overpayment must be made to Us within forty-five (45) days of notice to You. Any amounts not repaid may be recovered by Us by offsetting against any amounts otherwise payable to You under this Policy or by other reasonable means.

PAYMENT OF CLAIMS
All Benefits payable under this Policy will be payable to You.

EXTENSION OF BENEFITS
If Your Policy lapses while You are receiving Qualified Long-Term Care, it will not affect a claim beginning before the lapse. We will continue to provide Benefits for Qualified Long-Term Care beyond the date of the lapse for as long as You remain eligible without interruption. Continuous nursing home confinement shall include being transferred to another nursing home or receiving another level of Nursing Care in a nursing home or for the transfer back to a nursing home from a temporary/acute hospitalization.

This Extension of Benefits is subject to Your Maximum Lifetime Benefit, applicable Facility Daily Benefit Amount and all other Policy provisions.

CLAIM QUESTIONS
If there are questions regarding a claim or claim payment, please call or write Us: Auto-Owners Life Insurance Company, P.O. Box 30325, Lansing, MI 48909. We can be contacted at 1-517-323-1200.

APPEAL RIGHTS
If there is a disagreement with a claim determination because We have partially or fully denied Benefits, an appeal may be filed. Include the reason for the appeal and any documents that are pertinent to the situation. The request should be sent to Our Home Office within three (3) years of the time of filing written Notice of Claim.

We will make a Benefit determination, independent of the original determination, using Your medical records and the provisions of the Policy. We will provide a written decision within sixty (60) days of Our receipt of the appeal request.

GENERAL PROVISIONS

ENTIRE POLICY, CHANGES
This Policy, including the attached application, riders, endorsements or other papers, if any, make up the entire contract. No agent is allowed to change this Policy in any way. Changes can be made only by one of Our executive officers. Changes will not be valid unless recorded in writing and attached to this Policy.

INCONTESTABILITY PERIOD
During the first six (6) months, The Company will deny claims or rescind the Policy due to misrepresentations in the application that are material to Our acceptance for coverage.

For a Policy that has been in force for at least six (6) months but less than two (2) years, The Company will deny claims or rescind the Policy due to misrepresentations in the application that are both material to the acceptance for coverage and that pertains to the condition for which Benefits are sought.

After two (2) years from the Policy Date during Your lifetime, no misstatement, except fraudulent statements, made by You in the application for this Policy will be used to void this Policy or deny a Qualified Long-Term Care Insurance claim for loss incurred beginning after the two (2) year period.

We will not reduce or deny a claim after two (2) years from the Policy Date because a sickness or physical condition existed before the Policy Date unless the sickness or physical condition was excluded by name or specific description in this Policy.

LEGAL ACTION
No legal action may be brought to recover on this Policy until sixty (60) days after acceptable written Proof of Loss, as required in this Policy, has been furnished to Us. No such action may be brought more than three (3) years after the date such acceptable written Proof of Loss is required to be furnished to Us.

MISSTATEMENT OF AGE
If Your age shown on the Policy Data Page is wrong, the Benefits payable under the Policy will be changed to what the annual premium would have been if purchased at the correct age. If, because of a misstatement of Your age, We accept any premium which falls on a date when, according to the correct age, this Policy would not have been issued, Our liability will be limited to the refund of all premiums paid for the Policy.

CONFORMITY WITH STATE STATUTES
Any provision of this Policy which, on the Policy Date, is in conflict with the laws of the state in which it is delivered will be deemed to conform to such laws.

COVERAGE REDUCTION OPTION
The Owner has the right to reduce coverage and lower the premium on the Policy by reducing the maximum amount or reducing the daily Benefit amount.

The Owner may request to reduce coverage and lower the premium on the Policy by giving Us a written request. The age to determine the premium for the reduced coverage will be based on the age used to determine Your premium for the coverage currently in force. The effective date of the change will be the date We approve the request.

WHEN YOUR POLICY COVERAGE BEGINS
The date Your coverage under this Policy begins is listed on the Policy Data Page. All time periods begin and end at 12:01 A.M. at the place of Your primary residence.

WHEN YOUR POLICY COVERAGE ENDS
When one (1) of the following occurs, You will no longer be entitled to Benefits under this Policy:

- Nonpayment of premium (subject to the Grace Period and Waiver of Premium requirements); or
- Maximum Lifetime Benefits are exhausted; or
- The Owner elects to terminate this Policy; or
- We terminate this Policy for fraudulent statements made in the application (subject to the Incontestability Period provision); or
- Your death.

PORTABILITY
This Policy recognizes Qualified Long-Term Care provided to You anywhere in the United States by Providers duly licensed or certified in accordance with applicable state or federal law.

OWNERSHIP
You are the Owner of this Policy unless it is otherwise stated in the application for this Policy. The Owner of this Policy may exercise all rights of ownership and take any other action agreed to by Us, including changing the ownership of this Policy, without the consent of any other person, unless such consent is specifically required by law.

NON-PARTICIPATING
This is a non-participating Policy.

3% Compound Benefit Increase Rider

This rider is issued in consideration of the application and of the payment of an additional premium in the amount and for the period shown on the Policy Data Page of the Policy.

BENEFITS
We will increase Your Facility Daily Benefit Amount and Home and/or Community Care Daily Benefit Amount at a rate of three percent (3%) compounded annually, for each year that coverage remains continuously in force. The increase amount will be based on the Benefit amounts in effect at the time and will automatically become effective on each anniversary of the Policy Effective Date. Your unused Maximum Lifetime Benefit will increase in proportion to the increase in Your Facility Daily Benefit Amount and Home and/or Community Care Daily Benefit Amount.

In the event of reinstatement, the Facility Daily Benefit Amount and Home and/or Community Care Daily Benefit Amount will be the same as if the Policy had never lapsed.

CONDITIONS
This rider terminates:

(a) when We receive a written request to cancel this rider;
(b) when We terminate the Policy for fraud;
(c) the date Your Maximum Lifetime Benefit has been paid;
(d) upon Your death; or
(e) in conjunction with the Policy to which it is attached, subject to provisions of this Benefit.

We will refund, on a pro-rata basis, the portion of any premiums paid which were to apply to periods following the termination.

EXECUTED at Lansing, Michigan on the Policy Effective Date unless otherwise stated on the Policy Data Page.

John Doe
Signature of Policyowner and Date

If this rider is added after the original Policy Date this must be signed and dated.

Jane Secretary
Secretary

Joe President
President

Auto-Owners Life Insurance Company

5% Compound Benefit Increase Rider

This rider is issued in consideration of the application and of the payment of an additional premium in the amount and for the period shown on the Policy Data Page of the Policy.

BENEFITS
We will increase Your Facility Daily Benefit Amount and Home and/or Community Care Daily Benefit Amount at a rate of five percent (5%) compounded annually, for each year that coverage remains continuously in force. The increase amount will be based on the Benefit amounts in effect at the time and will automatically become effective on each anniversary of the Policy Effective Date. Your unused Maximum Lifetime Benefit will increase in proportion to the increase in Your Facility Daily Benefit Amount and Home and/or Community Care Daily Benefit Amount.

In the event of reinstatement, the Facility Daily Benefit Amount and Home and/or Community Care Daily Benefit Amount will be the same as if the Policy had never lapsed.

CONDITIONS
This rider terminates:

(a) when We receive a written request to cancel this rider;
(b) when We terminate the Policy for fraud;
(c) the date Your Maximum Lifetime Benefit has been paid;
(d) upon Your death; or
(e) in conjunction with the Policy to which it is attached, subject to provisions of this Benefit.

We will refund, on a pro-rata basis, the portion of any premiums paid which were to apply to periods following the termination.

EXECUTED at Lansing, Michigan on the Policy Effective Date unless otherwise stated on the Policy Data Page.

John Doe
Signature of Policyowner and Date
If this Rider is added after the original Policy Date this must be signed and dated.

Jane Secretary
Secretary

Joe President
President

Auto-Owners Life Insurance Company

Non-Forfeiture Benefit Rider

This rider is issued in consideration of the application and of the payment of an additional premium in the amount and for the period shown on the Policy Data Page of the Policy.

BENEFITS

We will provide You with a Non-Forfeiture Benefit if:

- this rider has been in force for three (3) years or more; and
- premium payments are discontinued for any reason other than being waived under the Waiver of Premium provision of the Policy.

The total of all Benefits paid for Qualified Long-Term Care services provided by this Non-Forfeiture Benefit will be equal to the greater of:

- the sum of all premiums paid for the Policy while this rider is in force, less the sum of all Benefits paid; or
- thirty (30) times the Facility Daily Benefit Amount in effect when premiums cease.

Payment of this Benefit will be subject to the provisions of this rider and to the Policy to which it is attached. The Non-Forfeiture Benefit will not include any premium waived under the Waiver of Premium provision of the Policy or any unearned premium returned by us. No further Benefit increases will occur under a Compound Benefit Increase Rider, if attached to the Policy.

CONDITIONS

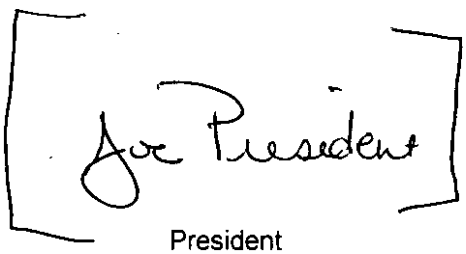
This rider terminates:

(a) when We receive a written request to cancel this rider;
(b) when We terminate the Policy for fraud;
(c) the date Your Maximum Lifetime Benefit has been paid;
(d) the date Your Non-Forfeiture Benefit has been paid;
(e) upon Your death; or
(f) in conjunction with the Policy to which it is attached, subject to provisions of this Benefit.

We will refund, on a pro-rata basis, the portion of any premiums paid which were to apply to periods following the termination.

EXECUTED at Lansing, Michigan on the Policy Effective Date unless otherwise stated on the Policy Data Page.

Secretary



President

Auto-Owners Life Insurance Company

Long-Term Care Application to the *Auto-Owners Life Insurance Company*

A. PERSONAL INFORMATION (Use separate application for each person)

Proposed Insured (print full name)	Height	Weight	Are you a US Citizen? ☒ Yes ☐ No
John Doe	6'0"	180	If no, please provide a valid resident card

Social Security No.	Birth Date	Gender	Driver's License No.
999-99-9999	1-1-51	M	D99999999

Telephone No.	Alternate No.	Best Time to Call	E-mail Address
(999) 999-9999	( )	9PM	doe@hotmail.com

Home Street Address (include city, state and zip code): 123 Any Street, Any City, AR 99999

I live: ☐ Alone ☒ With my spouse ☐ Other _____

Beneficiary*- I designate the following to receive any benefits or premium refund due me upon my death.

Full Name & Address of Beneficiary	Relationship	Social Security No.
Jane Doe 123 Any Street Any City, AR 99999	Spouse	555-55-5555

* Will be paid equally to surviving beneficiaries unless specified otherwise

Policyowner and/or Payor (If other than Proposed Insured)

Name of Owner and Relationship _____ Social Security/FEIN No. of Owner _____

Owner's Address _____

Name of Premium Payor _____

Billing Address _____

Bill: ☒ Annual ☐ Annual EFT ☐ Semi-Annual ☐ Semi-Annual EFT ☐ Quarterly ☐ Quarterly EFT ☐ Monthly EFT

Spousal Discount: ☐ Yes ☒ No Premium Amount for Payment Mode Selected $_____ Premium with Application $_____

B. LONG-TERM CARE COVERAGE DESIGNATION

1. Plan applied for:

☐ Basic - Nursing Home Care only, 7 day Bed Reservation

☐ Intermediate - Nursing Home Care, 14 day Bed Reservation, Home and/or Community Based Care & Services at 50% of Nursing Care Benefit Amount.

☒ Advanced - Nursing Home Care, 21 day Bed Reservation, Home and/or Community Based Care & Services at 100% of Nursing Care Benefit Amount.

2. Elimination Period: ☒ 30 Days ☐ 60 Days ☐ 90 Days

3. Benefit Period: ☐ 2 Years ☐ 4 Years ☒ 6 Years ☐ 10 Years

4. Daily Benefit Amount $ 100.00 ($50/day minimum - $250/day maximum in increments of $10/day)

5. Optional Coverages:

Coverage	Accept	Reject
3% Compound Benefit Increase Rider	☐	☒
5% Compound Benefit Increase Rider	☐	☒
Non-Forfeiture Benefit Rider	☐	☒

5% Compound Benefit Increase Rider: I have reviewed the outline of coverage and the graph that compares the benefit and premium of the policy with and without inflation protection. Specifically, I have reviewed the plan for the 5% Benefit Increase Rider, and I reject inflation protection.
Signed *John Doe* **If Rejected – Must Sign**

Non-Forfeiture Benefit Rider: I have been informed of my right to purchase the Non-Forfeiture Benefit Rider and any costs to have this option have been fully explained to me and I reject this Rider. Signed *John Doe* **If Rejected – Must Sign**

C. PROPOSED INSURED'S MEDICAL QUESTIONNAIRE

Please answer all questions (1-4) yes or no.

IF ANY OF THESE QUESTIONS (1-4) ARE ANSWERED YES, DO NOT SUBMIT THIS APPLICATION. YOU ARE NOT ELIGIBLE FOR THIS POLICY.	**Yes**	**No**
1. Have you had, do you have or have you **ever** been diagnosed or treated for any of the following medical conditions: Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), Human Immunodeficiency Virus (HIV), HIV Positive, Alzheimer's Disease, Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's Disease), Huntington's Chorea, Cirrhosis of the liver, Chronic Memory Loss, Senility, Dementia or Organic Brain Syndrome, Multiple Sclerosis (MS), Metastatic Cancer (Cancer that has spread from the original organ), Muscular Dystrophy (MD), more than one Transient Ischemic Attack (TIA/mini-stroke), more than one Stroke or Cerebrovascular Accident (CVA), Parkinson's Disease or Kidney Failure?	☐	☒
2. Are you receiving or has a recommendation been made that you receive: Adult Day Care, Assisted Living Services, Home Care, Nursing Home Care, or Care in a Home for the Aged or any other Facility or Institution?	☐	☒
3. Do you currently use any of the following: walker, wheelchair, respirator, quad cane (4-pronged cane), motorized cart, electric stair lift, supplemental oxygen or receive dialysis?	☐	☒
4. Do you currently need or use the assistance or supervision of another person in performing any of the following activities: Bathing, Dressing, Moving in/out of a bed or chair, Toileting, Bowel/Bladder Control, Eating, taking your medications, walking indoors, walking outdoors?	☐	☒

D. PROPOSED INSURED'S HEALTH HISTORY

Please answer all questions yes or no. Give details to yes answers in D4.	**Yes**	**No**
1. Within the past five years, have you received advice or medical treatment from a health care practitioner for any of the following conditions?		
a. Heart Attack, High Blood Pressure, Congestive Heart Failure (CHF), Heart Surgery, Angioplasty, Stroke, Transient Ischemic Attack (TIA/mini-stroke), Chest Pain, Angina, Irregular Heart Beat or other Heart condition?	☐	☒
b. Cancer, Tumor, Skin Ulcers, Hodgkin's Disease, Lymphoma, other Malignancy or Growth?	☐	☒
c. Diabetes: either Insulin-Dependent or Non-Insulin Dependent, Elevated Blood Sugar, Impaired Glucose Tolerance or Diseases of the Pancreas or Liver?	☐	☒
d. Brain Disorder, Mental, Emotional or Nervous Disorder, Depression, Confusion, Anxiety, Alcoholism, Drug or Substance Abuse, Fainting Spells, Blacking Out, Epilepsy, Seizures, Convulsions or other Neurological Disorder?	☐	☒
e. Emphysema, Asthma, Chronic Obstructive Pulmonary Disease (COPD), Shortness of Breath, Chronic Bronchitis, other Lung or Breathing Conditions?	☐	☒
f. Osteoarthritis, Rheumatoid Arthritis, Osteoporosis, Pain in the Muscles or Joints, Disorders of the Bones, Joints or Spine, Fractures, Hip, Knee or other Joint Replacement, Amputation or any Conditions Causing Crippling, Limited Motion or Requiring Adaptive Devices?	☐	☒
g. Paralysis, Numbness, Visual Disturbances, Balance Problems, Falls or Tremors?	☐	☒
h. Any other Conditions not mentioned above?	☐	☒
2. Has any future surgery, diagnostic test or medical procedure been planned, discussed or recommended?	☐	☒
3. Within the past five years have you:		
a. Received Home Care, Adult Day Care, Assisted Living Care, Care in a Nursing Home, Home for the Aged or other Institution/Facility?	☐	☒
b. Consulted with or been treated by a health professional for any reason not previously stated?	☐	☒
c. Received or are you currently receiving Workers' Compensation, Long-Term Disability, Social Security Disability (SSDI) or any other form of Disability Payments?	☐	☒

4. Details to yes answers for questions D1-3.

Ques. No.	Dates	Conditions, Treatments and any Residual Effects	Doctor Name & Address

5. Are you taking any prescription medication? (If yes, please list the medication and details.) ☐ ☒

Medication Name	Dose/Times per Day	How long, and why, have you been taking this medication?

6. When did you last visit your Primary Care Physician? 1-10-11

What was the reason for this visit? Physical

Name of Primary Care Physician	Address	Phone No.
Dr. Price	1000 Patient Lane	(444)444-4444

E. PROPOSED INSURED'S PERSONAL PROFILE

	Yes	No
1. Have you used tobacco in any form within the last 24 months?	☐	☒
2. Do you have a valid driver's license?	☒	☐
If yes, how many miles do you drive per week? 25		

F. PROPOSED INSURED'S OTHER COVERAGE AND REPLACEMENT INFORMATION

	Yes	No
1. Do you have another Long-Term Care Insurance policy and/or certificate pending or in force? (Including health care services contract or health maintenance organization contract.) If yes, please complete:	☐	☒
2. Have you ever been denied coverage for Long-Term Care Insurance?	☐	☒
a. If yes, what year and for what reason?		
3. Did you have another Long-Term Care Insurance policy or certificate in force during the last 12 months?	☐	☒
a. If yes, with which company?		
b. If yes, and that policy lapsed, when did it lapse?		
4. Are you currently receiving or eligible to receive benefits provided by Medicaid?	☐	☒
5. Do you intend to replace any of your medical or health insurance coverage with this policy?	☐	☒

Company Name	Coverage Type	Daily Benefit Amount

If yes, please complete below: **(Please also complete a replacement form)**

Company Name	Coverage Type	Daily Benefit Amount

G. AGENT'S REPORT

Agents please list the following:	Yes	No
1. Did you see the Proposed Insured?	☒	☐
2. Policies and certificates sold to the applicant which are in force:		
3. Policies and certificates sold in the past five (5) years to the applicant that are no longer in force:		

H. CONDITIONS OF: APPLICATION, RECEIPT, AUTHORIZATION AND NOTICE

CONDITIONS OF APPLICATION - I declare all questions have been asked, and all statements and answers in this application are correctly recorded, complete and true to the best of my knowledge and belief. The Company may rely and act on them.

I understand and agree:

(a) I understand and agree that coverage does not begin until this application is approved by Auto-Owners Life Insurance Company and a policy, with an effective date of coverage, is issued.

(b) For any policy issued, coverage under it will take effect as of the effective date shown on the policy data page. Receipt of my premium deposit does not constitute coverage under any Qualified Long-Term Care Insurance policy.

(c) That no agent may accept risk or pass on any eligibility requirement, make or alter the terms of the policy or waive any of Auto-Owners Life Insurance Company's rights or requirements.

(d) I understand that this application and my health statement both become part of any policy issued to me by Auto-Owners Life Insurance Company.

(e) That the application has been completed truthfully to the best of my knowledge and nothing has been purposefully omitted. I understand that my application may, in certain instances, be denied. If it is found that my answers are incorrect or untrue, or any material information was omitted from this application, and I have been approved for coverage, Auto-Owners Life Insurance Company may have the right to deny benefits or rescind my policy.

(f) I have read and understand the above Conditions of Application.

Receipt- I have received a copy of the:

		YES	NO
1.	Long-Term Care Insurance Policy Outline of Coverage	X	
2.	Shopper's Guide to Long-Term Care	X	
3.	Long-Term Care Potential Rate Increase Disclosure Form	X	
4.	Long-Term Care Insurance Personal Worksheet	X	
5.	Things You Should Know Before You Buy Long-Term Care Insurance	X	
6.	HIPAA Compliant Authorization	X	

Designation- Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this Long-Term Care Insurance policy for non-payment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid.

My Designee is (print full name): Jack Doe

Designee's Address: 124 Any Street, Any City, AR 99999

☐ I elect NOT to designate a person to receive this notice.

_____

IF REJECTED MUST SIGN AND DATE

AUTHORIZATION TO OBTAIN AND RELEASE MEDICAL INFORMATION

I Authorize the release of information to Auto-Owners Life Insurance Company. This release will also apply to its reinsurers, insurance support organizations and their representatives. It may concern me or my health. Medical, financial or personal details may be released. Also to be released is data about drug use, alcoholism and mental illness. This will be used by underwriters, company officers and medical personnel to evaluate my application for Long-Term Care Insurance or claims. Data may be released by physicians or practitioners. It may also be released by hospitals, clinics or other medical facilities. The Veterans Administration, the Medical Information Bureau, Inc. (MIB) may release data. My employer and any consumer reporting agencies may also release data. Insurance companies and their reinsurers who have information of care, treatment or advice about me may also release it. I understand that this authorization is valid for 24 months from the date it is signed. A copy of it is also valid. I acknowledge having received a copy and that I have read it, and that its terms, conditions and limitations, to which I agree have been explained to me. I understand I have the right to revoke this authorization at any time, subject to action on the authorization prior to the notice of revocation, by submitting a written request to Auto-Owners Life Insurance Company.

I Authorize my employer, any consumer reporting agency, other organization, institution or person having any records or knowledge of me or my health to release any financial or personal details to Auto-Owners, its reinsurer(s) or insurance support organizations and their representatives.

I Authorize the release of my Protected Health Information to the Owner of this policy in the event that a separate Owner is named for this policy.

Owner/Applicant: I Authorize the release of my Protected Health Information to the above named designee, any third party payor, as well as to the proposed insured listed on this application. This information includes but is not limited to, information about premium amount, payment method, coverage amount and any other information that may be revealed during the course of maintaining this policy.

NOTICE

Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and subjects such person to criminal and civil penalties.

CAUTION

If your answers in this application are incorrect or untrue, Auto-Owners Life Insurance Company may have the right to deny benefits or rescind your policy.

THE AGENT AND I CERTIFY that I have read, or the agent has read to me, the completed application. I realize that any false statement or misrepresentation in my application may result in loss of coverage under the policy (subject to the incontestability provision).

Signed in the state of Arkansas this 24th day of January, 2012.

John Doe
(Signature of Proposed Insured)

_____
(Signature of Owner – if Other than Proposed Insured)

Joe Agent
(Agent's Signature)

Joe Agent
(Agent's Name – Please Print)

xxx-xxxx
(Agency & Producer Code)

Application for Reinstatement of Qualified Long-Term Care Insurance Policy

Auto-Owners Life Insurance Company

A. PERSONAL INFORMATION

Insured (print full name)			Policy Number	Height	Weight
John Doe			025-999999-0	6'0"	180
Social Security No. 999-99-9999	Birth Date 1-1-51	Gender M	Driver's License No. D99999999		
Telephone No. (999) 999-9999	Alternate No. ( )	Best Time to Call 9PM	E-mail Address doe@hotmail.com		
Home Street Address (include city, state and zip code) 123 Any Street, Any City, AR 99999		I live: ☐ Alone ☒ With my spouse ☐ Other _____			

Policyowner and/or Payor (If other than Insured)

Name of Owner and Relationship _____ Social Security/FEIN No. of Owner _____

Owner's Address _____

Name of Premium Payor _____

Billing Address _____

B. INSURED'S MEDICAL QUESTIONNAIRE

Please answer all questions (1-4) yes or no.

IF ANY OF THESE QUESTIONS (1-4) ARE ANSWERED YES, DO NOT SUBMIT THIS APPLICATION. YOU ARE NOT ELIGIBLE FOR REINSTATEMENT.	**Yes**	**No**
1. Have you had, do you have or have you ever been diagnosed or treated for any of the following medical conditions: Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), Human Immunodeficiency Virus (HIV), HIV Positive, Alzheimer's Disease, Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's Disease), Huntington's Chorea, Cirrhosis of the liver, Chronic Memory Loss, Senility, Dementia or Organic Brain Syndrome, Multiple Sclerosis (MS), Metastatic Cancer (Cancer that has spread from the original organ), Muscular Dystrophy (MD), more than one Transient Ischemic Attack (TIA/mini-stroke), more than one Stroke or Cerebrovascular Accident (CVA), Parkinson's Disease or Kidney Failure?	☐	☒
2. Are you receiving or has a recommendation been made that you receive: Adult Day Care, Assisted Living Services, Home Care, Nursing Home Care, or Care in a Home for the Aged or any other Facility or Institution?	☐	☒
3. Do you currently use any of the following: walker, wheelchair, respirator, quad cane (4-pronged cane), motorized cart, electric stair lift, supplemental oxygen or receive dialysis?	☐	☒
4. Do you currently need or use the assistance or supervision of another person in performing any of the following activities: Bathing, Dressing, Moving in/out of a bed or chair, Toileting, Bowel/Bladder Control, Eating, taking your medications, walking indoors, walking outdoors?	☐	☒

C. INSURED'S HEALTH HISTORY

Please answer all questions yes or no. Give details to yes answers in C4.

	Yes	**No**
1. Within the past five years, have you received advice or medical treatment from a health care practitioner for any of the following conditions?		
a. Heart Attack, High Blood Pressure, Congestive Heart Failure (CHF), Heart Surgery, Angioplasty, Stroke, Transient Ischemic Attack (TIA/mini-stroke), Chest Pain, Angina, Irregular Heart Beat or other Heart Condition?	☐	☒
b. Cancer, Tumor, Skin Ulcers, Hodgkin's Disease, Lymphoma, other Malignancy or Growth?	☐	☒
c. Diabetes; either Insulin-Dependent or Non-Insulin Dependent, Elevated Blood Sugar, Impaired Glucose Tolerance or Diseases of the Pancreas or Liver?	☐	☒
d. Brain Disorder; Mental, Emotional or Nervous Disorder, Depression, Confusion, Anxiety; Alcoholism, Drug or Substance Abuse; Fainting Spells, Blacking Out, Epilepsy, Seizures, Convulsions or other Neurological Disorder?	☐	☒
e. Emphysema, Asthma, Chronic Obstructive Pulmonary Disease (COPD), Shortness of Breath, Chronic Bronchitis, other Lung or Breathing Conditions?	☐	☒
f. Osteoarthritis, Rheumatoid Arthritis, Osteoporosis, Pain in the Muscles or Joints, Disorders of the Bones, Joints or Spine, Fractures; Hip, Knee or other Joint Replacement, Amputation or any Conditions Causing Crippling, Limited Motion or Requiring Adaptive Devices?	☐	☒
g. Paralysis, Numbness, Visual Disturbances, Balance Problems, Falls or Tremors?	☐	☒
h. Any other Conditions not mentioned above?	☐	☒
2. Has any future surgery, diagnostic test or medical procedure been planned, discussed or recommended?	☐	☒
3. Within the past five years have you:		
a. Received Home Care, Adult Day Care, Assisted Living Care, Care in a Nursing Home, Home for the Aged or other Institution/Facility?	☐	☒
b. Consulted with or been treated by a health professional for any reason not previously stated?	☐	☒
c. Received or are you currently receiving Workers' Compensation, Long-Term Disability, Social Security Disability (SSDI) or any other form of Disability Payments?	☐	☒

C. INSURED'S HEALTH HISTORY (continued)

4. Details to yes answers for questions C1-3.

Ques. No.	Dates	Conditions, Treatments and any Residual Effects	Doctor Name & Address

	Yes	No
5. Are you taking any prescription medication? (If yes, please list the medication and details.)	☐	☒

Medication Name	Dose/Times per Day	How long, and why, have you been taking this medication?

6. When did you last visit your Primary Care Physician? 1-10-12
What was the reason for this visit? physical

Name of Primary Care Physician	Address	Phone No.
Dr. Price	1000 Patient Lane	(444)444-4444

D. INSURED'S PERSONAL PROFILE

	Yes	No
1. Have you used any tobacco products in the past 24 months?	☐	☒
2. Do you have a valid driver's license?	☒	☐
If yes, how many miles do you drive per week? 25		

E. CONDITIONS OF: APPLICATION, RECEIPT, AUTHORIZATION AND NOTICE

CONDITIONS OF APPLICATION

I declare all questions have been asked, and all statements and answers in this application are correctly recorded, complete and true to the best of my knowledge and belief. The Company may rely and act on them.

I understand and agree:

(a) I understand and agree that coverage does not begin until this application is approved by Auto-Owners Life Insurance Company and a policy, with an effective date of coverage, is issued.

(b) For any policy issued, coverage under it will take effect as of the effective date shown on the policy data page. Receipt of my premium deposit does not constitute coverage under any Qualified Long-Term Care Insurance policy.

(c) That no agent may accept risk or pass on any eligibility requirement, make or alter the terms of the policy or waive any of Auto-Owners Life Insurance Company's rights or requirements.

(d) I understand that this application and my health statement both become part of any policy issued to me by Auto-Owners Life Insurance Company.

(e) That the application has been completed truthfully to the best of my knowledge and nothing has been purposefully omitted. I understand that my application may, in certain instances, be denied. If it is found that my answers are incorrect or untrue, or any material information was omitted from this application, and I have been approved for coverage, Auto-Owners Life Insurance Company may have the right to deny benefits or rescind my policy.

(f) I have read and understand the above Conditions of Application.

AUTHORIZATION TO OBTAIN AND RELEASE MEDICAL INFORMATION

I Authorize the release of information to Auto-Owners Life Insurance Company. This release will also apply to its reinsurers, insurance support organizations and their representatives. It may concern me or my health. Medical, financial or personal details may be released. Also to be released is data about drug use, alcoholism and mental illness. This will be used by underwriters, company officers and medical personnel to evaluate my application for Long-Term Care Insurance or claims. Data may be released by physicians or practitioners. It may also be released by hospitals, clinics or other medical facilities. The Veterans Administration, the Medical Information Bureau, Inc. (MIB) may release data. My employer and any consumer reporting agencies may also release data. Insurance companies and their reinsurers who have information of care, treatment or advice about me may also release it. I understand that this authorization is valid for 24 months from the date it is signed. A copy of it is also valid. I acknowledge having received a copy and that I have read it, and that its terms, conditions and limitations, to which I agree have been explained to me. I understand I have the right to revoke this authorization at any time, subject to action on the authorization prior to the notice of revocation, by submitting a written request to Auto-Owners Life Insurance Company.

I Authorize my employer, any consumer reporting agency, other organization, institution or person having any records or knowledge of me or my health to release any financial or personal details to Auto-Owners, its reinsurer(s) or insurance support organizations and their representatives.

I Authorize the release of my PHI to the Owner of this policy in the event that a separate Owner is named for this policy.

Owner/Applicant: I Authorize the release of my PHI to the designee named on the application, any third party payor, as well as to the insured listed on this application. This information includes but is not limited to, information about premium amount, payment method, coverage amount and any other information that may be revealed during the course of maintaining this policy.

John Doe	1-24-12		
(Signature of Insured)	(Date)	(Signature of Owner – if other than Insured)	(Date)

TAX-QUALIFIED COMPREHENSIVE LONG-TERM CARE INSURANCE
PREMIUMS PAYABLE AS SHOWN ON PAGE 3

Auto-Owners Life Insurance Company

Long-Term Care Insurance

Potential Rate Increase Disclosure Form

1. **Premium Rate:**

   Premium rate that is applicable to you, and that will be in effect until a request is made and approved for an increase, is on the application.

2. **The premium for this policy will be shown on the schedule page of your policy.**

3. **Rate Schedule Adjustments:**

   Premium rate adjustments will be effective on the next anniversary date.

4. **Potential Rate Revisions:**

   This policy is Guaranteed Renewable. This means that the rates for this product may be increased in the future. Your rates can NOT be increased due to your increasing age or declining health but your rates may go up based on the experience of all policyholders with a policy similar to yours.

   If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one (1) of the following options:

   - Pay the increased premium and continue your policy in force as is.
   - Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)
   - Exercise your non-forfeiture option if purchased. (This option is available for purchase for an additional premium.)
   - Exercise your contingent non-forfeiture rights.* (This option may be available if you do not purchase a separate non-forfeiture option.)

***Contingent Non-Forfeiture**

If the premium rate for your policy goes up in the future and you didn't buy a non-forfeiture option, you may be eligible for contingent non-forfeiture. Here's how to tell if you are eligible:

You will keep some Long-Term Care Insurance coverage, if:

- Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table; and
- You lapse (not pay more premiums) within 120 days of the increase.

The amount of coverage (i.e., new maximum lifetime benefit amount) you will keep will equal the total amount of premiums you've paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining maximum benefit amount is less than the premiums you've paid, the amount of coverage will be that remaining amount.

Except for this reduced maximum lifetime benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter. Should you choose this contingent non-forfeiture option, your policy, with this reduced maximum benefit amount, will be considered "paid-up" with no further premiums due.

Example:

- You bought the policy at age sixty-five (65) and paid the $1,000 annual premium for ten (10) years, so you have paid a total of $10,000 in premium.
- In the eleventh (11) year, you receive a rate increase of 50%, or $500 for a new annual premium of $1,500, and you decide to lapse the policy (not pay any more premiums).
- Your "paid-up" policy benefits are $10,000 (provided you have at least $10,000 of benefits remaining under your policy).

Turn the Page

Contingent Non-Forfeiture
Cumulative Premium Increase over Initial Premium
That qualifies for Contingent Non-Forfeiture

(Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.)

Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

Auto-Owners Life Insurance Company

Lansing, MI 48909

Name John Doe Phone (999)999-9999

LONG-TERM CARE INSURANCE PERSONAL WORKSHEET

People buy Long-Term Care Insurance for a variety of reasons. Some don't want to use their own assets to pay for Long-Term Care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But Long-Term Care Insurance may be expensive, and may not be right for everyone.

By state law, The Insurance Company must fill out part of the information on this worksheet and **ask** you to fill out the rest to help you and The Company decide if you should buy this policy.

Premium Information

Policy form number(s) 50134 (3-11)

The premium for the coverage you are considering will be $ 1,201.00 per year.

This is a Guaranteed Renewable Policy. The Company's right to Increase Premiums: Auto-Owners (The Company) reserves the right to change the premiums for this policy in the future provided it raises rates for all policies in the same class in this state. Rate Increase History: The Company first sold Long-Term Care Insurance in 1989. This product was introduced in 2002. The Company has never raised its rates for any Long-Term Care policy.

Questions Related to Your Income

How will you pay each year's premium? **(check one)**

☐ From My Income ☒ From My Savings/Investments ☐ My Family Will Pay

Have you considered whether you could afford to keep this policy if premiums went up, for example, by 20%?

What is your annual income? **(check one)**

☐ Under $10,000 ☐ $10 - $20,000 ☐ $20 - $30,000 ☐ $30 - $50,000 ☒ Over $50,000

How do you expect your income to change over the next ten (10) years? **(check one)**

☒ No Change ☐ Increase ☐ Decrease

If you will be paying premiums with money received only from your income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Will you buy inflation protection? **(check one)** ☐ Yes ☒ No

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount? **(check one)**

☐ From My Income ☒ From My Savings/Investments ☐ My Family Will Pay

The national average annual cost of care in 2010 was $80,300, but this figure varies across the country. In ten (10) years the national average annual cost would be about $125,000 if costs increase 5% annually.

What elimination period are you considering?

Number of days 30 Approximate cost $ 3,100.00 for that period of care.

How are you planning to pay for your care during the elimination period? **(check one)**

☐ From My Income ☒ From My Savings/Investments ☐ My Family Will Pay

Questions Related to Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth? **(check one)**

☐ Under $20,000 ☐ $20 - $30,000 ☐ $30 - $50,000 ☒ Over $50,000

How do you expect your assets to change over the next ten (10) years? **(check one)**

☒ Stay About The Same ☐ Increase ☐ Decrease

If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your Long-Term Care.

Disclosure Statement

I. Applicant (check one)

☒ The information provided above describe my financial situation.

or

☐ I choose not to complete this information.

☐ I acknowledge that the carrier and/or its agent (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. I understand the above disclosures. I understand that the rates for this policy may increase in the future. **(This box must be checked)**

Signed: *John Doe* _____ Date 01 / 24 / 2012

(Owner)

II. Agent:

☒ I explained to the applicant the importance of completing this information.

Signed: *Joe Agent* _____ Date 01 / 24 / 2012

(Agent)

Agent's Printed Name: Joe Agent _____

III. Applicant (sign below - if applicable):

My agent has advised me that this policy does not appear to be suitable for me. However, I still want The Company to consider my application.

Signed: _____ Date __ __ / __ __ / __ __ __ __

(Owner)

The Company may contact you to verify your answers.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

AUTO-OWNERS LIFE INSURANCE COMPANY, P.O. BOX 30325, LANSING, MI 48909

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to your application, you intend to lapse or otherwise terminate existing accident and sickness or Long-Term Care Insurance and replace it with an individual Long-Term Care Insurance policy to be issued by Auto-Owners Life Insurance Company. Your new policy provides thirty (30) days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or Long-Term Care Insurance coverage you now have and terminate your present policy only if, after due consideration, you find that purchase of this Long-Term Care coverage is a wise decision.

STATEMENT TO APPLICANT BY AGENT

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations which I call to your attention:

1. Health conditions that you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy for similar benefits to the extent such time was spent under the original policy.

3. If you are replacing existing Long-Term Care Insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above “Notice to Applicant” was delivered to me on:

5-1-11
Date

Joe Agent
Signature of Agent

John Doe
Signature of Owner

Joe Agent
Typed Name of Agent

123 W. 44th St. Little Rock, AR
Address of Agent

Auto-Owners Life Insurance Company

THINGS YOU SHOULD KNOW BEFORE YOU BUY LONG-TERM CARE INSURANCE

Long-Term Care Insurance	• A Long-Term Care Insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it. • You should not buy this insurance policy unless you can afford to pay the premiums every year. Remember that the company can increase premiums in the future. • The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.
Medicare	• Medicare does not pay for most Long-Term Care.
Medicaid	• Medicaid will generally pay for Long-Term Care if you have very little income and few assets. You probably should not buy this policy if you are now eligible for Medicaid. • Many people become eligible for Medicaid after they have used up their own financial resources by paying for Long-Term Care services. • When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets. • Your choice of Long-Term Care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.
Shopper's Guide	• Make sure the insurance company or agent gives you a copy of a book called the National Association of Insurance Commissioners' "Shoppers Guide to Long-Term Care Insurance." Read it carefully. If you have decided to apply for Long-Term Care Insurance, you have the right to return the policy within thirty (30) days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.
Counseling	• Free counseling and additional information about Long-Term Care Insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.
Facilities	• Some Long-Term Care Insurance contracts provide for benefit payments in certain facilities only if they are licensed or certified, such as in assisted living centers. However, not all states regulate these facilities in the same way. Also, many people move to a different state from where they purchased their Long-Term Care Insurance policy. Read the policy carefully to determine what types of facilities qualify for benefit payments, and to determine that payment for a covered service will be made if you move to a state that has a different licensing scheme for facilities than the one in which you purchased the policy.

SERFF Tracking Number:	*AOIC-127752553*	*State:*	*Arkansas*
Filing Company:	*Auto-Owners Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*AR-LTC-10/11*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*Long-Term Care*		
Project Name/Number:	*Long-Term Care/AR-LTC-10/11*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved	01/30/2012

Comments:
Attached please find Auto-Owners Life Insurance Companies Certification of Compliance with Rule 19 and the Certificate of Readability.

Attachments:
AR Certif of Compliance with Rule 19 test.pdf
readability.pdf

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved	01/30/2012
Bypass Reason:	Auto-Owners Life Insurance Company will be using an updated application which is attached to the Form Scheduled for your apporval.		

Comments:

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved	01/30/2012
Bypass Reason:	This is a form filing only. There will be no change in rates with this filing.		

Comments:

		Item Status:	Status Date:
Satisfied - Item:	Outline of Coverage	Approved	01/30/2012

Comments:
Long-Term Care Outline of Coverage Form number 50392 (1-11)

Attachment:
50392 (01-11).pdf

		Item Status:	Status

SERFF Tracking Number:	*AOIC-127752553*	*State:*	*Arkansas*
Filing Company:	*Auto-Owners Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:	*AR-LTC-10/11*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*Long-Term Care*		
Project Name/Number:	*Long-Term Care/AR-LTC-10/11*		

Satisfied - Item: Statement of Variability — Approved — **Date:** 01/30/2012

Comments:

Attached please find the Statement of Variability

Attachment:

Statement of Variability.pdf

Certificate of Compliance with

Arkansas Rule and Regulation 19

Insurer: Auto-Owners Insurance Company

Form Number(s): 50134 (3-11) et al

I hereby certify that the filing above meets all applicable Arkansas requirements including those of Rule and Regulation 19.

Signature of Company Officer

Gayle A. Fisher
Name

Assistant Vice President, Life Operations
Title

January 23, 2012
Date

AUTO-OWNERS LIFE INSURANCE COMPANY
Certification of Readability

I hereby certify, to the best of my knowledge and belief, that the following forms have the respective Flesch Scores which meet the readability requirements of the Arkansas Department of Insurance.

Gayle A. Fisher, Assistant Vice President, Life Operations

Form 50134 (3-11) Policy Front Jacket
Flesch Score: 66.41

Form 61976 (8-11) Long-Term Care Policy Pages
Flesch Score: 50.21

Form 50479 (1-11) 3% Compound Benefit Increase Rider
Flesch Score: 58.01

Form 50129 (1-11) 5% Compound Benefit Increase Rider
Flesch Score: 60.52

Form 50130(1-11) Non-Forfeiture Benefit Rider
Flesch Score: 68.32

Various policy forms submitted as part of this filing have been excluded from readability scoring. The reason for exclusion include 1) form language prescribed by rules and regulations of state and federal statutes; and/or 2)form does not contain policy coverage or exclusion provisions. The following policy forms have been excluded from readability scoring:

Form 50126 (11-10) Long-Term Care Application

Form 61961 (7-11) Statement of Insurability

Form 61674 (10-09) Potential Rate Increase Disclosure Form

Form 50410 (1-11) Personal Worksheet

Auto-Owners Life Insurance Company
P.O. Box 30325
Lansing, Michigan 48909
(517) 323-1200

TAX-QUALIFIED COMPREHENSIVE LONG-TERM CARE INSURANCE
OUTLINE OF COVERAGE
FOR POLICY FORM 50134

NOTICE TO BUYER

This Policy may not cover all of the costs associated with Long-Term Care incurred by the buyer during the period of coverage. The buyer is advised to carefully review all Policy limitations.

CAUTION

The issuance of this Long-Term Care Insurance Policy is based upon Your responses to the questions on Your application. A copy of Your application is included in the Policy. If Your answers are incorrect or untrue, Auto-Owners Life Insurance Company may have the right to deny Benefits or rescind Your Policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of Your answers are incorrect, contact Auto-Owners Life Insurance Company (Us) at the above address.

1. THIS POLICY IS AN INDIVIDUAL POLICY OF INSURANCE

2. PURPOSE OF OUTLINE OF COVERAGE

This outline of coverage provides a very brief description of the important features of the Policy. You should compare this outline of coverage to outlines of coverage for other Policies available to You. This is not an insurance contract, but only a summary of coverage. Only the individual Policy contains governing contractual provisions. This means that the Policy sets forth in detail the rights and obligations of both You and the insurance Company. Therefore, if You purchase this coverage, or any other coverage, it is important that You READ YOUR POLICY CAREFULLY!

3. FEDERAL TAX CONSEQUENCES

This Policy is intended to be a federally tax-qualified Long-Term Care Insurance contract under Section 7702B(b) of the internal revenue code of 1986, as amended and will be endorsed to conform to changes in that definition. You should consult with Your attorney, accountant or tax adviser regarding the tax implications of purchasing this Long-Term Care Insurance.

4. TERMS UNDER WHICH THE POLICY MAY BE CONTINUED IN FORCE OR DISCONTINUED

(a) **RENEWABILITY**: THIS POLICY IS GUARANTEED RENEWABLE. This means You have the right, subject to the terms of Your Policy, to continue this Policy as long as You pay Your premiums on time. Auto-Owners Life Insurance Company cannot change any of the terms of Your Policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

(b) **Waiver of Premium**

After You have satisfied Your Elimination Period as shown on the Policy Data Page of the Policy, You will not be required to continue to pay premiums due in order to keep this Policy in force as long as: (i) You continue to receive Qualified Long-Term Care covered under the Policy; and (ii) You have not exhausted Your Maximum Lifetime Benefit.

Once You are no longer eligible for Benefits, premium payments begin again if Your Policy is to remain in force subject to (b)(ii).

5. TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS. We reserve the right to change on a class basis the table of premium rates of all Policies of this form number and all attached additional Benefits of their respective form numbers. In the event of a change in the table of premium rates, the change will apply to this Policy on the next annual Policy date

following the date of change in the premium rate tables. We will send You notice thirty (30) days or more before the due date of any increased premium.

6. TERMS UNDER WHICH THE POLICY MAY BE RETURNED AND PREMIUM REFUNDED

(a) Thirty (30) Day Right to Examine Policy

If the Policy is not satisfactory for any reason, it can be returned to Us or Your agent within thirty (30) days of the date it was delivered. We will refund any premium You have paid within thirty (30) days. The Policy will be considered to have never been issued.

(b) Return of Unearned Premium

If Your Policy terminates due to cancellation or death, We will refund, on a pro-rata basis, the portion of any premiums You paid, which were to apply to periods following the termination. We will pay the refund directly to You, Your estate or the Owner.

7. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE

If You are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from Auto-Owners Life Insurance Company.

Neither Auto-Owners Life Insurance Company nor its agents represent Medicare, the federal government or any state government.

8. QUALIFIED LONG-TERM CARE COVERAGE

Policies of this category are designed to provide coverage for one (1) or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community or in the home.

This Policy provides coverage in the form of a fixed dollar indemnity Benefit for covered Long-Term Care expenses, subject to Policy Facility Daily Benefit Amount, Home and/or Community Care Daily Benefit Amount, the Maximum Lifetime Benefit, the Elimination Period and all included Policy provisions.

9. BENEFITS PROVIDED BY THIS POLICY

We provide Benefits for the following types of Qualified Long-Term Care when You are a Chronically Ill Individual subject to Your Plan of Care, Maximum Lifetime Benefit, Facility Daily Benefit Amount and Home and/or Community Care Daily Benefit Amount as listed on the Policy Data Page of the Policy.

(a) Benefit Period Based On

Maximum Lifetime Benefit	$ [219,000.00]
Facility Daily Benefit Amount	$ [100.00]
Home and/or Community Care Daily Benefit Amount	$ [100.00]
Elimination Period	[30] days

(b) Maximum Lifetime Benefit

The total amount of coverage available under the Policy to pay for Qualified Long-Term Care. It applies to the combined total of all Benefit payments. The amount that applies on the Policy Date is shown on the Policy Data Page of the Policy. The Maximum Lifetime Benefit is subject to increase when the Compound Benefit Increase Rider is purchased.

(c) Facility Daily Benefit Amount

The dollar amount, which We will pay You for each day You receive Qualified Long-Term Care. The Facility Daily Benefit Amount is subject to increase when the Compound Benefit Increase Rider is purchased.

(d) Home and/or Community Care Daily Benefit Amount

The dollar amount, which We will pay You for each day You receive Qualified Long-Term Care in Your home or other community-based setting. The Home and/or Community Care Daily Benefit Amount is subject to increase when the Compound Benefit Increase Rider is purchased.

(e) Elimination Period

The number of days for which no Benefit is payable. Your Elimination Period starts on the date that Benefits would otherwise begin and is in effect for the number of days shown on the Policy Data Page. The Elimination Period must be satisfied only once during the life of Your Policy.

(f) Contingent Non-Forfeiture Benefit

If a substantial premium rate increase is incurred, We will provide You with the option to: pay the increased premium, reduce Your Maximum Lifetime Benefit to a level that is supported by Your current premium or to continue coverage under the Contingent Non-Forfeiture Benefit. Under the Contingent Non-Forfeiture Benefit, Your Policy will remain in force with a reduced Policy Maximum Lifetime Benefit equal to the sum of the premiums You have paid. This means that a reduced Maximum Lifetime Benefit will be payable instead of the full Policy Maximum Lifetime Benefit.

(g) Coverage Reduction Option

You have the right to reduce coverage and lower the premium on Your Policy by reducing the maximum amount or reducing the daily Benefit amount.

IMPORTANT DEFINITIONS

(a) Plan of Care

A written guide for Qualified Long-Term Care designed especially for You that:

1. Fairly, accurately and appropriately addresses Your needs for Long-Term Care;
2. Is acceptable to Us, You and Your physician; and
3. Utilizes Qualified Long-Term Care.

The Plan of Care will specify the type, frequency and providers of all the services You require. The Plan of Care must be prescribed by a Licensed Health Care Practitioner.

The Plan of Care may need to be updated periodically, as appropriate, based on Your condition.

(b) Chronically Ill Individual

An individual who, within the prior twelve (12) months, has been certified by a Licensed Health Care Practitioner as being unable to perform, without Substantial Assistance from another individual, two (2) or more of the Activities of Daily Living for an expected period of at least ninety (90) days due to a loss of functional capacity; or an individual who has been certified by a Licensed Health Care Practitioner as requiring Substantial Supervision to protect himself or herself from threats to health and safety due to Severe Cognitive Impairment. Written certification must be renewed or updated at least every twelve (12) months.

(c) Substantial Assistance

The support of another person who must provide physical hands-on assistance or who must be within arm's reach of You to prevent, by physical intervention if necessary, injury while You perform an Activity of Daily Living.

(d) Substantial Supervision

Continual supervision which may include cueing by verbal prompting, gestures or other demonstrations by another person that is necessary to protect You from harming Yourself or others when You have a Severe Cognitive Impairment.

COVERED SERVICES

Benefits are only paid while You receive Qualified Long-Term Care. All Benefits, except otherwise noted, are subject to Your Elimination Period, Facility Daily Benefit Amount or Home and/or Community Care Daily Benefit Amount and Maximum Lifetime Benefit and included Policy provisions. The daily Benefit is the Facility Daily Benefit Amount or the Home and/or Community Care Daily Benefit Amount, depending on the site where care is provided. The cumulative sum of all Benefits paid cannot exceed the Maximum Lifetime Benefit as shown on the Policy Data Page.

(a) Facility Benefits
We will pay You the Facility Daily Benefit Amount, subject to Your Elimination Period, for each day of care that is provided in a Skilled Nursing Facility.

(b) Home and/or Community Care Benefits
We will pay You the Home and/or Community Care Daily Benefit Amount, subject to Your Elimination Period, for each day You receive Home Health Care, Home Health Aide and Personal Care Attendant Services, Adult Day Care and Hospice Care. When You are receiving Qualified Home and/or Community Care, during Your Elimination Period, per Your Policy Data Page, We will only require You to receive three (3) days of Qualified Long-Term Care, during a Sunday through Saturday week, to equal seven (7) days toward Your Elimination Period.

(c) Bed Reservation
If You are receiving Qualified Long-Term Care in a Skilled Nursing Facility, Assisted Living Facility or other facility covered under the Policy and must be hospitalized temporarily, We will pay the Facility Daily Benefit Amount for up to the number of days listed on the Policy Data Page per calendar year. Unused days cannot be carried into the next calendar year. This Benefit is subject to Your Maximum Lifetime Benefit.

OPTIONAL BENEFITS

(a) Compound Benefit Increase Rider
If chosen, Auto-Owners Life Insurance Company will increase Your Facility Daily Benefit Amount and Home and/or Community Care Daily Benefit Amount at a rate of three percent (3%) or five percent (5%) of the previous year's dollar amount for each year that coverage remains continuously in force, up to Your lifetime. Your Maximum Lifetime Benefit will be increased by the same proportion as the daily Benefit.

(b) Non-Forfeiture Benefit Rider
If chosen, Auto-Owners Life Insurance Company will establish a shortened Benefit period based on the length of time Your Policy was in force and subsequently lapsed according to the terms set in the rider when Your Policy has been in force for at least three (3) years.

10. LIMITATIONS AND EXCLUSIONS
This Policy will not pay a daily Benefit when:

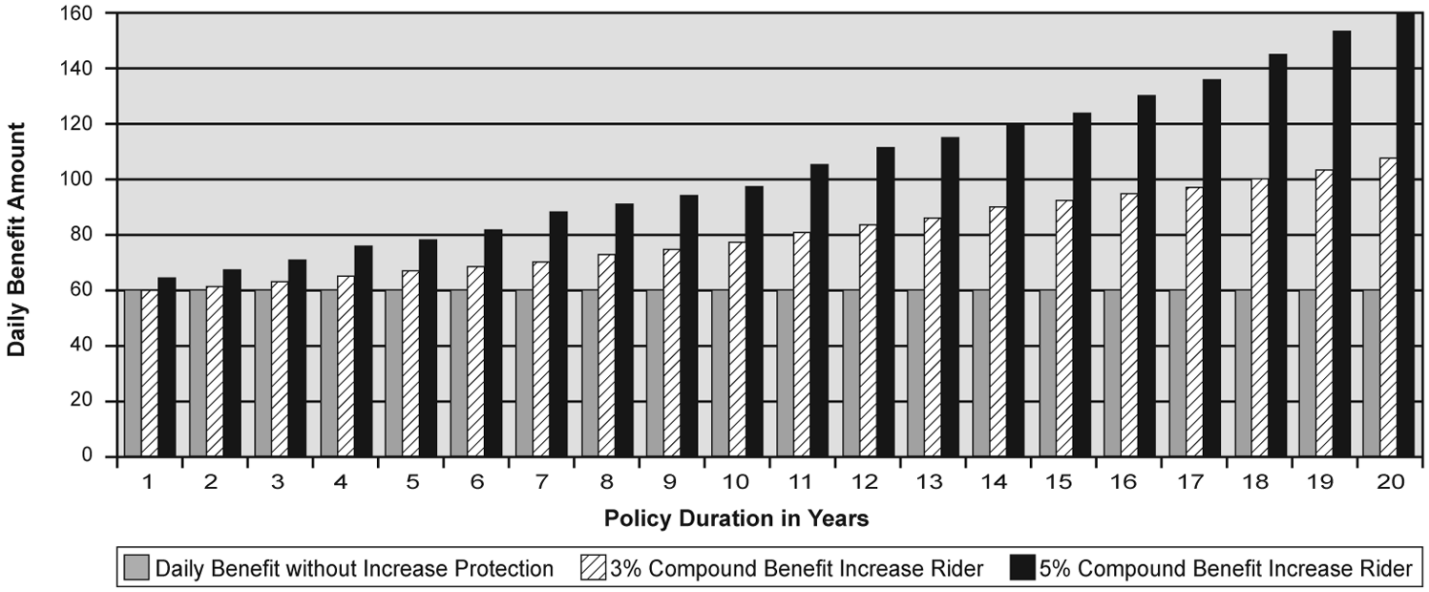
(a) care is provided by Immediate Family Members or for which the insured is not obligated to pay;
(b) care is provided outside the United States of America or its possessions;
(c) care is given for which no charge is normally made in the absence of insurance;
(d) care results directly or indirectly from an intentionally self-inflicted injury;
(e) care is provided free of charge by or in a Veteran's Administration or federal government facility;
(f) care results from mental illness or nervous disorder without demonstrable organic disease. (This Policy will cover disorders with demonstrable organic cause such as Alzheimer's disease or similar forms of senility or irreversible dementia that results in Severe Cognitive Impairment);
(g) care results from alcoholism or drug addiction;
(h) illness, treatment or medical condition is caused by the commission of a felony;
(i) illness, treatment or medical condition arising out of participation in a felony, riot or insurrection;
(j) care is provided during the Elimination Period;
(k) care is not included in the Plan of Care; or
(l) care given is not Qualified Long-Term Care.

This Policy does not contain a preexisting conditions limitation.

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

11. RELATIONSHIP OF COST OF CARE AND BENEFITS

Because the costs of Long-Term Care services will likely increase over time, You should consider whether and how the Benefits of this plan may be adjusted. The following graph compares the Benefits between a Policy with the Compound Benefit Increase Rider and a Policy without the rider.



12. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS

The Policy pays a Benefit if You are a Chronically Ill Individual due to Severe Cognitive Impairment. Severe Cognitive Impairment can result from Alzheimer's disease and similar forms of senility and irreversible dementia.

13. PREMIUM

Qualified Long-Term Care Policy	$ [1,201.00]
Compound Benefit Increase Rider	$ [ ]
Non-Forfeiture Benefit Rider	$ [ ]
Discount(s) Total	$ [ ]
Total Annual Premium	$ [1,201.00]

14. ADDITIONAL FEATURES

(a) Medical Underwriting. The Policy will be issued based on Your answers to the questions on Your application and any additional information that may be needed to complete the evaluation process.

(b) Appeal Procedure. If Auto-Owners Life Insurance Company denies a claim for Benefits in whole or in part, You will be notified of the reasons for denial. If You disagree with Auto-Owners Life Insurance Company's denial, You may request a formal review of Your claim. The request must be in writing and sent to Auto-Owners Life Insurance Company within sixty (60) days after the denial.

(c) Third Party Designee. In addition to Yourself, You may designate an individual to be notified of lapse or termination. Notice will not be given until thirty-one (31) days after a premium is due and unpaid and shall be deemed to have been given as of five (5) days after the date of the mailing. The Owner may change the designee at any time by sending Us written notification.

15. CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE POLICY.

Statement of Variability

The following fields on the Policy Front Jacket, Policy Form 50134 (3-11) are indicated in the filing as variable:

Secretary (Secretary of Auto-Owners Life Insurance Company)
President (President of Auto-Owners Life Insurance Company)

The following fields on the Policy Data Page 50135 (7-11) are indicated in the filing as variable. These fields will vary based on individual policy characteristics and choice:

Insured (name of insured)
Owner (name of owner)
Gender (gender of insured)
Issue Age *(age of insured)*
Policy Number *(policy number)*
Policy Date *(effective date)*
Premium Class *(Standard, Preferred)*
Maximum Lifetime Benefit at Policy Inception *($32,000 -$905,000)*
Benefit Period *(2, 4, 6, 10 years)*
Facility Daily Benefit Amount *($50-250)*
Home and/or Community Care Daily Benefit Amount *($25-250)*
Elimination Period *(30, 60, 90 days)*
Bed Reservation *(7, 14, 21 days)*
Base Coverage Premium *(annual premium amount for base policy)*

(Additional Benefits:
Non-Forfeiture Benefit Rider *(annual premium amount for rider if chosen)*
3% Compound Increase Rider *(annual premium amount for rider if chosen)*
5% Compound Increase Rider *(annual premium amount for rider if chosen)*)

Total Annual Premium (*total annual premium for benefits chosen)*

Premium Mode Options:
Monthly *(total premium on a monthly basis)*
Quarterly *(total premium on a quarterly basis)*
Semi-Annual *(total premium on a semi-annual basis)*
Annual *(total premium on an annual basis)*

The following fields on the Non-forfeiture Benefit Rider, Policy Form 50130 (1-11) are indicated in the filing as variable:

Secretary *(Secretary of Auto-Owners Life Insurance Company)*
President *(President of Auto-Owners Life Insurance Company)*

The following fields on the 3% Compound Benefit Increase Rider, Policy Form 50479 (1-11) are indicated in the filing as variable:

Signature of Policyowner and date *(Signature of Policyowner and date)*
Secretary *(Secretary of Auto-Owners Life Insurance Company)*
President *(President of Auto-Owners Life Insurance Company*

The following fields on the 5% Compound Benefit Increase Rider, Policy Form 50129 (1-11) are indicated in the filing as variable:

Signature of Policyowner and date *(Signature of Policyowner and date)*
Secretary *(Secretary of Auto-Owners Life Insurance Company)*
President *(President of Auto-Owners Life Insurance Company)*

The following fields on the Individual Long-Term Care Insurance Policy Outline of Coverage 50392 (1-11) are indicated in the filing as variable. These fields will vary based on the individual policy characteristics and choice.

Maximum Lifetime Benefit *($32,000 -$905,000)*
Facility Daily Benefit Amount *($50-250)*
Home and/or Community Care Daily Benefit Amount *($25-250)*
Elimination Period *(30, 60, 90 days)*

Qualified Long-Term Care Policy *(annual premium amount)*
Compound Benefit Increase Rider *(annual premium for rider if chosen)*
Non-Forfeiture Benefit Rider *(annual premium for rider if chosen)*
Discount(s) Total *(amount of annual discount if applicable)*
Total Annual Premium *(total annual premium for benefits chosen)*